Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
Mental Health Block Grant

Program and Fiscal Monitoring Report
South Carolina
February 22-26, 2016

PROGRAM MONITORING REPORT

Executive Summary

The Division of State and Community Systems Development, Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services conducts at least 10 monitoring visits each year to ensure states receiving mental health block grants (MHBG), pursuant to Section 1911 of the Public Health Service Act (PHSA) comply with grant requirements. As required by Subpart III, Section 1945 (g) of the PHSA, the CMHS conducts these investigations in partnership with the states to monitor the expenditures of MHBG funds;

- Assess compliance with required funding agreements and assurances;
- Identify strengths (e.g., best practices, exemplary efforts) of state and local mental health systems; and
- Recommend areas for improvement and possible technical assistance.

The SAMHSA monitoring process is an opportunity for the state to receive objective analysis of their systems, service delivery, data and quality assurance, access to care, workforce development and issues addressing behavioral health equity. The recommendations included in this report are a result of documentation provided from the state, interviews with state and local staff, Mental Health Planning Council and consumers and families.

The South Carolina Department of Mental Health's (SCDMH) mission is to support the recovery of people with mental illnesses, giving priority to adults with serious and persistent mental illness and to children and adolescents with serious emotional disturbances. The SCDMH serves approximately 100,000 citizens with mental illnesses, approximately 30,000 of whom are children and adolescents.

The SCDMH system has more than 700 portals, which citizens can access mental health services and include:

- Seventeen community-based, outpatient mental health centers, each with clinics and satellite offices, which serve all 46 counties in our state;
- Four licensed hospitals, including one for substance abuse treatment;
- Four nursing homes, including three for veterans;
- Operation of a Forensics program and the Sexually Violent Predator Treatment Program
- More than 20 specialized clinical service sites (SCDMH offices that provide some type of clinical care, but do not offer a full array of services found in a center or clinic);
- Twenty, South Carolina hospitals with Tele-Psychiatry services;
- More than 140 community sites (non-mental health entities or businesses where SCDMH staff regularly and routinely provide clinical services), and 480 school-based service program sites.

Community Mental Health Centers (CMHCs) provide comprehensive mental health services, offering outpatient, home-based, school, and community-based programs to children, adults and families throughout South Carolina. All 17 DMH CMHCs are accredited by the Commission on

Accreditation of Rehabilitation Facilities (CARF), an independent, non-profit accreditor of health and human services. Each SCDMH community mental health center has an advisory board, with nine to 15 members, including at least one medical doctor. Center board members meet monthly.

The level of commitment to technology in South Carolina is one of its greatest strengths. One example includes the Tele-Psychiatry initiative. As of July 10, 2015, SCDMH's innovative Tele-Psychiatry program had provided 23,548 psychiatric consultations in emergency departments across South Carolina. The Program was developed to meet the critical shortage of psychiatrists in South Carolina's underserved areas, and assist hospital emergency rooms by providing appropriate treatment to persons in a behavioral crisis, using real-time, state-of-the-art video-and-voice technology that connects SCDMH psychiatrists to hospital emergency departments throughout the state.

Built on the success of Tele-Psychiatry services to emergency departments, SCDMH has equipped its hospitals, mental health centers, and clinics to provide psychiatric treatment services to its patients via Telepsychiatry. Currently, SCDMH is providing approximately 1,200 psychiatric services per month to SCDMH consumers via Tele-Psychiatry. The use of this technology enables SCDMH to efficiently, utilize the limited number of psychiatrists available to treat the most patients. Of special note, in January 2015, a Columbia-based SCDMH Neurology Service began providing tele-neurology consultations to its Patrick B. Harris Psychiatric Hospital in Anderson. The service, established as an addition to previously available neurological services, increases accessibility of such consultations for clients in this upstate facility, while reducing travel time and expense.

SCDMH school-based services are now available in 480 schools across South Carolina. SCDMH is in the process of adding 20 clinicians to further expand this service, and expects to have service available in more than 500 South Carolina schools by 2016. There is strong emphasis on community-based care for children and on family preservation. In addition, training on evidence-based practices and delivery of services through a school-based model helps to reduce acknowledged, deficits in access and workforce issues for rural areas. There is strong interagency cooperation among the Department and the social services systems, cooperation that enhances early intervention, prevention, and continuity of care for children and youth, and families.

The SCDMH has 11 programs included as "Blue Ribbon" Programs. Seven of these programs have a direct impact on children and families. The Blue Ribbon Programs include Tele Psychiatry, services for the deaf, Multi-Systemic Therapy for youth, school-based services, housing and homeless services, and the Assessment and Resource Center (ARC). The ARC is a Children's Advocacy Center accredited through the National Children's Alliance in Washington, D.C. Towards Local Care is a program to assist patients transitioning from inpatient institutions to community-based care.

The Department continues to offer Peer Support Certification Classes and uses Peer Support Specialists throughout the state mental health system. Since the last monitoring visit, SCDMH has continued to expand Peer Support opportunities for consumers. South Carolina was the

second state to negotiate a reimbursable rate for Peer Support services from the Centers for Medicare and Medicaid Services.

In an effort to enhance partnerships and address workforce shortage issues, leadership from SCDMH has worked hard to establish affiliations with more than 50 educational institutions in South Carolina and more than five other states. SCDMH's affiliation with the University of South Carolina includes activity therapy, clinical counseling, medical students, social work, psychology interns, psychology graduate studies, and residents and fellows in psychiatry. Residents from the MUSC Medical Center Residency Training Program receive educational experiences and supervision in Psychiatry, through scheduled rotations at the Charleston Dorchester Mental Health Center (CDMHC). SCDMH also has a multi-million dollar contract with the University of South Carolina to support residency training for medical students, social workers, psychology interns, and fellows in psychiatry.

A point of positive distinction for South Carolina is with the leadership of the South Carolina Mental Health State Planning Council. For two consecutive terms, the council has been led by a consumer with serious mental illness. Members are active and involved in their role of advocating for the mental health system and identified a strong, respectful, working relationship with SCDMH leadership. The Council membership reflects the stakeholder community, adult consumers, family members of children, representatives from advocacy organizations, and representatives from all the required state agencies.

No state enjoys having to respond to disaster or emergency events. Unfortunately, South Carolina has had to respond to an emergency event with the Emanuel shooting. After meeting with both the state and the local CMHC, it was important to include in this report the overall behavioral health response to this tragedy. On the evening of Wednesday, June 17, 2015, ten people were victims of a shooting during a prayer service at Emanuel AME Church in Charleston, nine of the victims died. In collaboration with local law enforcement and community groups, the staff from Charleston-Dorchester MHC (CDMHC), were able to respond immediately in the wake of the tragedy. The Center reached out to victims, their families, the Emanuel Community, the Office of the Mayor, first responders (Emergency Medical Services law enforcement, and the coroner's office), the Media, victims' advocates, and the community at large. The following is a brief summary of services provided by Charleston-Dorchester MHC and its partners following the shootings. CDMHC quickly collaborated with multiple community partners. Together, these partners were able to provide immediate access to care, via: Family Assistance Center, Church Assistance Center, Regular and timely debriefings, Funeral planning meetings, Phone banks and interviews, Community assistance at the Mental Health Centers, Support presence at prayer vigils, Support presence at every victim's wake and funeral and the Highway to Hope RV presence at the memorial service at Emanuel AME.

After meeting with staff, the planning council, families, and consumers, it was identified that South Carolina still has areas of improvement to their system of care. They include the following recommendations for improvement and possible technical assistance.

Recommendations for Improvement and Technical Assistance

- SCDMH needs to improve areas that are directly related to access to care, data exchange and collection, utilization and retention concerns within the state's system of care for populations. These populations include:

    - Eighteen, 26 year-olds;
    - Youth In Transition;
    - Consumers with both a substance use disorder and a serious mental illness in rural areas;
    - Individuals involved in the criminal and juvenile justice system; and
    - LGBT and Hispanic/Latino individuals accessing services.

- SCMH needs to operationalize statewide medication practices, policies, or algorithms that ensure evidence-based care is rendered and strategic cross training for medical staff and medication prescribers at FQHC's.

The Mental Health Planning Council requested Technical Assistance in the following areas:

- Recruiting new members that support diversity and also include young adult membership; and
- Role identification and sphere of influence with key stakeholders.

Based on focus group discussions it is recommended, the Client Affairs Coordinators (CAC)

- Video Conference with all the CAC's statewide, on a monthly basis; and
- Meet with the Mental Health Planning Council on a consistent basis through video conference.

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Administration of Mental Health Services and Leadership Perspective

The South Carolina Department of Mental Health (SCDMH) was established in 1821 and is the third oldest mental health system in the country. The SCDMH is an integrated system of care designed to meet the behavioral health needs of adults, children, and adolescents. The Department provides assessment, diagnosis, and treatment to its priority populations through a network of 17 Community Mental Health Centers (CMHCs) and 44 mental health clinics, which serve as satellite locations for their respective CMHC. The Department also operates four specialized inpatient facilities. Unlike mental health centers that are private, not-for-profit organizations in most other states, CMHCs in South Carolina are part of the state's public mental health system. The CMHCs provide services within their respective counties and operate within the policies and guidelines set by SCDMH. The CMHCs' service areas range from part of a county to as many as seven counties. The CMHCs across the state offer transitions for clients who relocated in South Carolina by providing access to Department inpatient facilities, if needed.

The Department is governed by a seven-member Mental Health Commission, whose members are appointed to five-year terms by the Governor with the consent of the State Senate. The Commission hires the SCDMH State Director.

The SCDMH also operates four nursing care facilities, although not necessarily psychiatric nursing care facilities. The Department has 900 beds in its nursing home operation, making it the largest provider of nursing home services in the state. One of the nursing facilities is used as a geriatric residency program for medical students at the University of South Carolina.

The Department has instituted the principles of recovery and resiliency in the state mental health system. The Department has in place ongoing efforts to heighten awareness and reduce the stigma associated with mental illness. The SCDMH promotes the recovery and resiliency efforts in its internal newsletter for staff, using its Speakers Bureau, issuing media press releases, using the South Carolina website, http://sc.gov and scheduling the state director for presentations at professional and public engagements. Each year, the department displays its Art of Recovery programs at eight locations in the state.

The CMHCs provide services to adults, children, and families. The transition of youth to the adult system of care takes place at the CMHC level. All of the CMHCs are three-year accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), and the Joint Commission accredits the inpatient facilities on the Accreditation of Healthcare Organizations (JCAHO). In the area of adult services, the SCDMH has implemented Assertive Community Treatment (ACT) for adults.

Collaboration among SCDMH and other state agencies is essential to many of the Department's efforts. The Department has a document called *South Carolina Department of Mental Health Blue Ribbon Programs and Initiatives*, which defines the efforts of interagency coordination that are in place. The SCDMH has 11 programs included as "Blue Ribbon" Programs. Seven of these programs have a direct impact on children and families. The Blue Ribbon Programs

include Tele-Psychiatry, services for the deaf, Multi-systemic Therapy (MST) for youth, school-based services, housing and homeless services, and the Assessment and Resource Center (ARC).

The Department has staff who work in nine Department of Juvenile Justice offices and 12 staff who work in the Department of Social Services Offices; also, 232 mental health counselors provide counseling services in 405 schools. The SCDMH staff also serves on the Veterans Policy Academy and the Joint Council on Adolescents. The South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) and the SCDMH have a Co-Occurring State Incentive Grant (COSIG) from the Substance Abuse and Mental Health Services Administration (SAMSHA). The SCDMH also has interagency affiliations with the Department of Education, the Department of Juvenile Justice, the Department of Disabilities and Special Needs, the Department of Health and Environmental Control, the Employment Security Commission and the Department of Veterans Affairs.

The SCDMH has a Multi-cultural Council; the Department focuses on the importance of cultural competency in the system of care. The Department considers cultural competency as part of its mission, believing that cultural competency is driven by leadership and information, and should be client and staff oriented. The Department leadership believes multi-culturalism should be embedded in all the agency's organizational units. The Department makes continuous efforts to recruit, retain, and develop a culturally diverse workforce. The SCDMH Multicultural Council is charged with the responsibility to advise and guide the agency leadership in the creation of a linguistically and culturally competent workforce. The Department is focused on ensuring the workforce is reflective of the diversity of the population served in the local communities.

The SCDMH has a commitment to staff training. Online learning systems in place allow staff to take training that is required by regulatory and accrediting agencies. In fiscal year (FY) 2010, 61 training modules were offered online. Of the 61 modules, 29 are mandatory and are offered on an annual basis to meet CARF and Occupational Safety and Health Administration (OSHA) standards.

State Agency Leadership Perspective

The legacy of strong leadership has been the cornerstone of success in South Carolina. The state has to lead the country in numerous innovations and has plans to continue this trend. The Commissioner articulated the following as his goals for future expansion.

Expand Training Opportunities – SCDMH has a commitment to staff development and training. There is an online learning management system in place, which allows staff to participate in training required by regulatory and accrediting agencies. One hundred fifty-two training modules are offered online to meet The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), Occupational Safety and Health Administration (OSHA) and the Department of Health and Environmental Control (DHEC) standards. Curriculums have been developed for staff, which outlines those modules that are required for their particular job duties and responsibilities. These online trainings allow staff to participate in the required training in place, as schedules permit, eliminating the need to travel to attend the training in a traditional classroom setting and the associated loss in productivity during travel times. SCDMH

has estimated the man-hour cost savings generated by the online learning modules for FY 2013-2014 exceeded $5 million.

Expand Use of Electronic Medical Record – The Department's goal is to provide technologically appropriate resources for the efficient and effective provision of care for patients receiving inpatient services. Electronic Medical Records reduce required storage space for physical storage media (i.e. paper records), assimilate various components of a patient's medical record into a single access point, reduce the cost of record transference, improve overall operating efficiency, increase portability and accessibility of health information, reduce medical errors, provide for ease of updating to current technologies including coding, and will transition the Department into compliance with Medicare and Medicaid preferred technologies.

Expand Use of Telepsychiatry – SCDMH partnered with the Duke Endowment, South Carolina Department of Health and Human Services, the University of South Carolina School of Medicine and the South Carolina Hospital Association to create the SCDMH telepsychiatry program to address the overcrowding of psychiatric patients in local hospital Emergency Departments (ED). It is a cutting-edge statewide service delivery model that provides remote access for EDs in rural areas of South Carolina to psychiatrists whenever psychiatric consultation services are required. First of its kind nationally, and has been widely recognized for its effectiveness. Just as with the previously mentioned program, which is still expanding, SCDMH has begun the expanded use of telepsychiatry in its CMHC's and Inpatient Facilities. The CMHCs program utilizes telepsychiatry in a two-fold manner: Center-to-Clinic and Center-to-Center. Center-to-Clinic Tele-psychiatry connects the primary CMHC with its satellite mental health clinics. Center-to-Center Tele-psychiatry connects the CMHCs to each other. In addition, the Inpatient Facilities can capitalize on the use of telepsychiatry, as well. This expanded use of technology, in the form of telepsychiatry, provides the opportunity for the Department's 17 CMHCs, 46 Mental Health Clinics, and 4 Inpatient Facilities to utilize a common pool of physicians to deliver services to consumers and patients without the loss of productivity associated with travel time.

Expand Emergency Psychiatric Services – In addition to the Telepsychiatry ED consultation program, SCDMH, through its CMHC's, utilizes a number of measures to divert individuals in a behavioral health crisis from community hospital EDs. The crisis intervention measures include entering into contracts with hospitals; with community psychiatric beds to admit patients referred by Centers; funding all or part of a mental health professionals salary to provide on-site consultation to hospital EDs, and funding the mobile crisis program in Charleston

Expand Use of School-Based Services – SCDMH school-based mental health (SBMH) services improve access to needed mental health services for children and their families. The information exchange and collaboration that develops between school teachers, school counselors and administrators and school-based mental health staff improves early identification and treatment for children in need; and for those children and families in need of services, the SBMH program services increase school attendance, reduce discipline referrals and decrease drop-out rates. These positive outcomes for the student and their families also positively correlate with a decreased risk of violence in the school and community.

Expanded Use of Mental Health Professionals (MHP) in Emergency Departments – The MHP provides consultative services to patients experiencing psychiatric emergencies in the ED and facilitates linkage to appropriate resources. Evidence supports the assertion that MHPs placed in EDs to augment the mental health resources, currently available, have a direct impact on the overall treatment of patients presenting with possible mental health issues. MHPs support the determination process for appropriateness for inpatient admission, and therein, the absolute number of patients admitted versus those discharged the same day, and they positively affect the overall effectiveness of navigating patients presenting with potential mental health issues through the ED process. These placements create partnerships between SCDMH and the placement hospitals and leverage the resources of all.

Enhance Workforce Development – As summarized in a recent article, "the pool of qualified mental health professionals is not keeping pace with the population that needs their services, and in some cases, is decreasing." In addition, according to the South Carolina Graduate Medical Education Advisory Group in response to Proviso 33.34 (E), "the demographics of the physician workforce in South Carolina do not reflect the racial composition of South Carolina's population." In addition, there exists a bottleneck in medical residency slots. These circumstances, exacerbated by the low salaries offered by state government, will necessitate creative solutions to recruitment, retention, and graduate medical education. This is a top priority for leadership.

Increase Community Supportive Housing – SCDMH has a long history of making efforts to foster more permanent, supportive community housing for its patients. Appropriate housing is often the single biggest factor in determining whether a patient with serious psychiatric impairments can be successfully discharged or is able to remain successful in their recovery in the community. SCDMH is seeking new funds for the next three years to increase supportive community housing for its patients. Funds will be used for rental assistance in supported apartments and for transitioning patients into independent living.

Expand Behavioral Health Homes - In an effort to develop a comprehensive array of services, increase access to said services, ensure adequate choices for patients for services they need, and address the whole health needs of patients, SCDMH is seeking to develop behavioral health homes. In the SCDMH model of a behavioral health home, it would build a comprehensive array of services around the particular needs of a patient, including coordinating and integrating behavioral health care and primary health care, and establishing linkages to community supports and resources. Rather than expecting a patient to navigate a complex medical environment of dispersed and sometimes fragmented-services, the behavioral health home would create a single point of contact for patients around, which the sphere of services revolves.

Under technical assistance from the National Academy for State Health Policy, SCDMH has partnered with the South Carolina Department of Health and Human Services (SCDHHS), the South Carolina DAODAS, the University of South Carolina School of Medicine, and Mental Health America – South Carolina to build an integrated behavioral health home model. The Priority Outcomes for the collaboartion are (1) to determine the feasibility of an integrated behavioral health home model for targeted adult populations; (2) to identify and sustain payment

reform incentives for quality of care improvements; and, (3) to employ evidence-based workforce development resources to address provider capacity gaps for integrated practices.

Performance Data, Quality Improvement and Decision Support

The ability to electronically, exchange key medical information among public and private health care providers is essential to a successful collaborative care model. A common, secure method to share information, informs treatment decisions, strengthens care coordination and care transitions, and better ensures continuity of care for uninsured and at risk populations. It is also an important component in achieving long-term, system redesign for ongoing quality and efficiency improvements.

Synectics for Management Decisions, Inc. (Synectics)

As the acting agent for SAMHSA, for the distribution of funds to State Mental Health Authorities (SMHA), through the Behavioral Health Services Information System (BHSIS) State Agreements to help support BHSIS-related activities, Synectics has engaged the SCDMH in an Agreement by which SCDMH will collect and report mental health treatment services data.

SCHIEx is a statewide technology and policy infrastructure developed to address this need. In 2006/2007, the SC Data Warehouse was leveraged to develop a statewide master patient index and record linking service, key infrastructure components for Health Information Exchange (HIE). The index included over 90 percent of the state's population, and development was followed by a series of production pilots, including a Healthy Connections Viewer and a SCDMH telepsychiatry initiative. In 2009, SCHIEx became the designated exchange in the State HIE Cooperative Agreement Program and by 2011 had expanded its technology and governance framework statewide.

SCHIEx is governed by SC Health Information Partners (SC HIP), a not-for-profit entity based in South Carolina. Its purposes are to operate a secure health information exchange and to carry out those activities that will facilitate the utilization of health information in ways that improve the quality and efficiency of healthcare and patient safety.

SCHIEx is built on national, open standards for interoperability. It offers three exchange services.

1. Query Based Exchange – automated, bi-directional discovery and sharing of medical summaries using SCHIEx core technology and an interoperable Electronic Health Record (EHR) system. It's based on *integrating the Healthcare Enterprise* document sharing profiles – so that standardized medical summaries called continuity of care documents or CCDs (now CCDAs) are exchanged between SCHIEx participants in a peer-to-peer fashion. Participants access available CCDs from any other SCHIEx participant treating the same patient seamlessly from inside the EHR system. This service includes gateways with the state's public health immunization registry and eHealth Exchange, enabling reporting and retrieving immunization histories, veteran health exchange, a connection with the Georgia Health Information Network, and testing is underway with Department of Defense. The query-based exchange manages access to medical summaries for over one million unique patients.

2. SCHIEx Clinical Viewer - a web portal that enables authorized users to view and download clinical documents that are available via SCHIEx Query Based Exchange.
3. SCHIEx DIRECT – a secure, standards-based messaging service (health email) for sending protected health information, including information subject to special protections directly to another provider. It complies with *The DIRECT Project* protocol and applicability statement. CCDs may be attached to a DIRECT message and transmitted to other authorized providers. SCHIEx supports basic DIRECT and DIRECT XDR implementations.

Data Warehouse (Strength)

The Health and Demographics Section of the South Carolina Revenue and Fiscal Affairs Office (RFA), a neutral service entity in South Carolina state government, became a central setting to house data and to link persons across multiple service providers. The Office began its work with a limited number of agencies, private providers, and non-profit organizations. It was the vision of the RFA, agencies and those organizations that helped to propel the most expanded version that exists today. These agencies and organizations recognized the need for program evaluation and outcomes that encompassed information from other systems. The need to better understand disparities that exist in health, education, law enforcement and social services, was also a driving force to integrate data from these systems. Through a series of statutes and agreements, agencies and organizations entrust their data systems with the RFA, while retaining control of their own data at all times. The philosophy for the data warehouse: "It is the entire human experience that influences health and social well-being and should, therefore, be captured in an integrated data system." RFA developed a series of algorithms using various combinations of personal identifiers to create its own unique identifier, enabling statistical staff to "link across" multiple providers and settings. Hence, it allows for linkages, while protecting the confidentiality of the client. "Requests" to link data must be approved by all participating agencies and organizations.

The SCDMH has specific, system-wide performance standards, chosen by the Department and predicated on recognized clinical and administrative standards consistent with a recovery model. Dashboards, monthly reports, quarterly administrative summaries, listserv, and video-conferencing are used to ensure that data underpin decision-making at both the state and local levels. Satisfaction measures include access, participation in treatment, improvement in functioning, and social connection. Clinical functioning for adults is assessed using the Global Assessment of Functioning Scale (as needed) and for children using the Child Behavior Checklist, which is conducted at six-month intervals. All CHMCs adhere to quality standards promulgated by CARF. The state acknowledges clients, and the state Planning Council does not have an active role in monitoring or compliance activities.

Electronic Medical Record (Strength)

- The Outpatient Electronic Medical Record (EMR) is used in all 17-community mental health centers. Future goals include;
- Expansion of online clinical documentation beyond basic forms (e.g. Screening Form, Discharge Summary, etc.);
- Continuing to utilize Electronic Prescribing (ePrescribing) services;
- Researching the purchase of an Inpatient EMR as funds become available, and

- Sharing (with patient consent ONLY) clinical data with the South Carolina Health Information Exchange (SCHIEx) for continuity of care across providers.

Recommendation:
Currently, the state does not collect any data on the LGBT population in the mental health system. It is recommended that CIS Data Screening includes LGBT, non-binary gender identification, and gender-specific screening questions related to physical and reproductive health.

Adult Services

Mental health services are provided through the state's network of 17 CMHCs and 44 mental Health clinics. Services provided to adults with serious mental illness (SMI) include:

- Supported Employment (SE) services;
- The Towards Local Care Program;
- ACT;
- Crisis intervention;
- Assessment;
- Individual, family, and group therapy;
- Behavioral health screening;
- Mental health service plan development;
- Nursing services;
- Medication monitoring;
- Case management;
- Psychosocial rehabilitative services;
- Family support;
- Behavioral modification;
- Peer Support services;
- Continuing treatment and support;
- Respite services; and
- Dual diagnosis substance abuse and mental health treatment.

The SCDMH has programs in place that use innovative technology and best practice standards. In the area of adult services, the state provides Telepsychiatry. The SCDMH, in a partnership with the South Carolina Department of Health and Human Services and the South Carolina Hospital Association, obtained a grant from the Duke Endowment to ensure access to psychiatric consultation is available in all hospital EDs 24-hours a day, seven days a week.

Individual Placement & Supported Employment Program (IPS) (Strength)
Individual Placement and Support Employment program is an evidence-based program and provides consultation, training, and fidelity monitoring for the establishment and growth of patient employment, focusing on evidence-based practices that result in gainful employment in the community for persons with SMI.

In fiscal year 2014, the supported employment programs achieved a 51.2 percent average competitive employment rate for people with SMI. During this period, IPS had a total of 320 new people enroll in its programs and 216 new job placements. Nationally, among the 14 states participating in the IPS Dartmouth/Johnson & Johnson studies, South Carolina was ranked second in the highest average employment rate. In the last three years, South Carolina has been ranked second among the 14 states.

IPS program data reports, a person employed through IPS programs averaged an annual change in income of $6,391. There is a substantial decrease in hospital admissions and bed-day utilization on the consumers served one-year before receiving IPS services and one-year after receiving IPS services.

ACT-Like Programs

In South Carolina, specific modifications to the original ACT model were made based on a statewide research project. This project was designed to determine, which of the original ACT components are critical for effectiveness and, which can be altered to fit local needs while still producing positive outcomes. Based on the research, essential components of ACT were identified and a modified fidelity scale was developed to include these elements. In addition, an outcomes data collection protocol was implemented. Since, 2013 CMHC's have been implementing the ACT-like program. The outcome data supports the goal of the delivery of effective programming and generation of positive outcomes with a modified version of the ACT evidence-based practice. Emergency room visits, hospital admissions, and hospital days (both within the SCDMH system and private hospitals) are the most notable positively impacted areas.

Peer Support (Strength)

In 2004, SC became the second state to negotiate a reimbursable peer support service with the Department of Health and Human Services. Certified Peer Support Specialists (CPSS) use their own experiences with mental illness to help others acquire, develop, and expand their rehabilitation skills in order to move forward in recovery. Since the service was authorized, a self-report service evaluation has been required to evaluate the effectiveness of PSS. In 2011, program evaluation reviewing service patterns usage, inpatient admission, and length of stay was conducted to determine if or how CPSS has affected individuals receiving CPSS at SCDMH and compare them to patients who had not. Individuals who received 50+ hours of peer support annually, have significant reduction in the need for inpatient care and crisis services and drastically decreased psychiatric necessity, nurse, or mental health professional.

Trauma Informed Care Training

A Trauma Informed Workgroup was established in 2012 by the SC Joint Council on Children and Adolescents Workforce Committee. Its goal was to develop training to ensure all child, and adolescent clinical care providers are Trauma Informed. The Workgroup identified existing trauma-dedicated employees at two state agencies, SCDMH and the SC Department of Juvenile Justice (DJJ). Core competencies were identified, including input from 12 child-serving agencies and organizations, and were later endorsed by the Joint Council on Children and Adolescents. SCDMH and DJJ provided trainers, travel, equipment, and learning materials, and held Trauma Informed Care training for professionals from child serving agencies, childcare programs, law enforcement, hospitals/medical practices, family court systems, volunteer groups, and mentor programs.

Integration of Mental Health and Primary Care

Bi-Directional Integration: SCDMH's Partnerships for Integration of Primary Care and Behavioral Health. SCDMH's experience with primary care integration has included the following examples.

South Carolina Primary Care and Behavioral Health Integration Project: A collaborative opportunity to partner with the South Carolina Primary Health Care Association and its affiliated community health centers to establish a blueprint for how to best enhance access to both primary and behavioral health care for individuals served.

Aiken-Barnwell Mental Health Center (ABMHC) & Margaret J. Weston Community Health Center (MJWCHC). In August 2012, ABMHC placed a full-time behavioral healthcare consultant (BHC) at the MJWCHC - Clearwater site. The BHC provided an array of short-term behavioral health services, crisis intervention, and consultation to the medical doctors. In addition, a second BHC was deployed to MJWCHC. MJWCHC staff participated in the FY 2013 community forum providing a presentation to stakeholders on the project Beckman Community Mental Health Center (BCMHC)

SCDMH deployed a Mental Health Counselor at Uptown Family Practice contracted through BCMHC. This collaboration allowed the issues of financial concerns, availability/convenience, education, quality of care and concerns with stigmas to be less of a barrier. Individuals were referred from the primary care physician due to concerns regarding mental health. Working closely with the primary care providers allowed for patients to gain appropriate services and assisted with freeing up valuable time for an increase in medical appointments. This partnership directed patients to appropriate care to meet their needs and promoted mental health.

Certifications

In an effort to ensure SCDMH staff has adequate training to affect the changes required to integrate effectively, behavioral health care and primary care, several SCDMH staff members have completed the nationally-recognized Primary Care Behavioral Health Certificate Program from the University of Massachusetts Medical School, Department of Family Medicine and Community Health.

SCDMH has also had Community Mental Health Center staff members complete the Care Management and Navigatory Training Certificate Program from the University of Massachusetts Medical School, Department of Family Medicine and Community Health.

Practice Criteria/Expectations include the following: (1) providers will be expected to endorse and practice the behavioral health home model core components and practice "no wrong door" through evidence-based training; (2) providers will be trained and expected to adhere to, identified behavioral health home quality improvement metrics; and (3) evidence-based training will be implemented for primary care, behavioral health, community support and other providers/stakeholders.

The state Work Plan also includes consideration for the following topics: consumer engagement; cross-system collaboration and partnership; target population; engaging and linking providers with community-based services; and payment.

Accessibility, Coordination, and Continuity

TelePsychiatry

SCDMH launched its Telepsychiatry Consultation Program in April 2009. This innovative program utilizes real-time, state-of-the-art, video-and-voice technology that connects SCDMH psychiatrists to hospital emergency departments throughout the state for addressing the critical shortage of psychiatrists in South Carolina's underserved areas. This program has been so successful that it was recognized as part of the 2015 Bright Ideas program by the Harvard University, Ash Center for Democratic Governance and Innovation at the John F. Kennedy School of Government. The Telepsychiatry Consultation Program was among 124 programs selected as this year's Bright Ideas, which come from all levels of government and are at the forefront of innovative government action.

Additionally, SCDMH's telepsychiatry program partnered with The Duke Endowment (TDE), the University of South Carolina School of Medicine, the South Carolina Hospital Association, and the South Carolina Department of Health and Human Services (SC DHHS), received four grants to provide psychiatric consultations (via telemedicine) in EDs across South Carolina beginning in March of 2009. Since July 2012, the program is funded by TDE, state appropriations, SC DHHS, and via subscription fees from participating hospitals. As of October 26, 2014, 20 hospitals are connected to the telepsychiatry program. There have been nearly 21,200 consultations since the program's inception, with recommendations to divert 43 percent of these patients from an inpatient admission.

Clinical Care Coordination (Strength)

In 2012, SCDMH began planning to create a new branch of service called Care Coordination, a patient-centered, assessment-based, multidisciplinary approach for individuals with high-risk, multiple, chronic, and complex conditions. In January 2013, SCDMH launched the Office of Clinical Care Coordination (OCCC) with the goal of improving outcomes for patients and reducing healthcare costs. The staff contains a mix of Bachelor- and Master-level care coordinators. Twenty-eight of the staff, have attained certification through the Certified Program in Integrated care Management Program as Certified Integrated Care Managers offered through the University of Massachusetts Medical School. Provision of Care Coordination services results in:

- Decreased re-hospitalizations and emergency room visits;
- Increased utilization of primary care physicians; and
- Increased detection and treatment of Depression.

Because of its proven effectiveness, Care Coordination is now a required service for any provider that wishes to contract with Medicaid. Medicare and other major insurance companies are following suit. Care Coordinators (CCs) offer patients assistance with accessing various community resources that will support their recovery. Key features of the service include in-

home visits and reporting, and monitoring of consumers' progress in collaboration with referral sources. Each consumer is given a comprehensive care assessment, which identifies any medical, dental, housing, employment, education or other community supports or advocacy service needs, and the care coordinator, knowledgeable about the local community's resources, links the consumer to those resources and then monitors until successful completion. The OCCC has established several statewide initiatives with the SCDHHS, and other partners including a pilot project with a Medicaid Managed Care Organization, and is working diligently to implement CCC services as consumer's transition to the community from hospitals and corrections facilities.

In FY 2015, OCCC received 11,026 referrals and provided services to 8,842 distinct clients. They are on track in exceeding these numbers well before the current fiscal year ends.

Recommendation:
Expansion of the OCCC program to assist with decreasing gaps in services.

Toward Local Care
Another imitative to address unmet needs and gaps in services for individuals transitioning from inpatient institutions into the community is the Toward Local Care (TLC) program. This program also provides services and supports, to help individuals remain in their communities and avoid re-hospitalization. All of the CMHC's has a TLC program, with capacity ranges from 10-149. Program types include community care residence, home-share, supported apartments, rental assistance, and level of service. As of July 2014, 3,769 consumers have received services through these residential and treatment options. A research comparison was completed by the state and found that of TLC participants', SCDMH inpatient use before and during TLC, revealed an 84 percent reduction in the number of consumers requiring SCDMH hospitalization, and a 95 percent reduction in the number of days in a SCDMH inpatient facility.

Homeless Services
The SCDMH Housing and Homeless Program has funded the development of more than 1,600 housing units across the state for persons with mental illnesses. HUD Shelter Plus Care programs are located in 14 counties and provide rental assistance to more than 350 patients and their family members who were formerly homeless.

The Health and Human Services Projects for Assistance in Transition from Homelessness (PATH) Formula Grant Program provides funding for targeted outreach and clinical services to persons with SMI and co-occurring disorders who are homeless. Programs are currently located in the Columbia, Greenville, Spartanburg, Myrtle Beach, and Charleston areas.

DMH is the lead agency for the SSI/SSDI Outreach, Access and Recovery (SOAR) initiative. SOAR, a SAMHSA best practice, is a partnership with the Social Security Administration and South Carolina Disability Determination Services that increases access to Social Security disability benefits for people with serious mental illnesses who are homeless or at risk of homelessness.

Innovation: Assessment/Mobile Crisis
Assessment/Mobile Crisis (AMC) is a psychiatric emergency services program of Charleston/Dorchester Mental Health Center (CDMHC), created in 1987. The AMC team

comprises 7.5 Master's level clinicians and a Master's level team leader. When called by law enforcement, night or day, rain or shine, mobile crisis team members will go anywhere in the community, except emergency departments, to provide triage, assessments, and referrals. The service is available to anyone in psychiatric distress. CDMHC's AMC is the only 24/7 psychiatric emergency response team of its kind in South Carolina. AMC partners with the Low Country Crisis Negotiators' team to assist at bridge jumping, barricade, and hostage scenes. The behavioral health expert sent to the scene can often get the person in crisis directed to treatment.

Innovation: Highway to Hope RV Project
The Highway to Hope RV (RV) of the CDMHC (launched in 2010) provides immediate psychiatric care to adults and children in the Charleston and Dorchester counties in a mobile setting. It visits rural areas known as underserved. The RV project functions as a mobile mental health clinic providing a full range of services including; Crisis Intervention; Assessment; Case Management; Individual and family therapy; and Medication management. Staffing includes a counselor, a psychiatrist, a nurse, and other mental health professionals. Fees are based on an individual's and family's ability to pay. Third party payments through private insurance, Medicaid, Medicare, and self-pay are accepted. As with all services provided by SCDMH, no one is turned away due to the inability to pay. Additionally this project eliminates disparities and improves access to **services.**

Criminal Justice
SCDMH provides The National Alliance on Mental Illness' Crisis Intervention Training (CIT) program which provides training and consultation to law enforcement regarding de-escalation of encounters with persons in psychiatric and emotional crises. In FY 2014, 2,527 law enforcement officers across the state were trained in the CIT program. SCDMH also provides a biennial forensics forum, which allows for interagency training and networking opportunities between the criminal justice and mental health agencies.

SCDMH Jail Diversion/Forensic Services provides consultation and promotes alliances and partnerships in local jurisdictions for coordination of services for offenders with mental illness. All 17 SCDMH community mental health centers and their clinics provide mental health services to jails and detention facilities, with services in 38 of the 46 counties in South Carolina. Only Dorchester, Lee, Darlington, Florence, Marion, Orangeburg, and Calhoun County jails do not receive mental health services from SCDMH, CMHC's. Mental health services in jails/detention facilities include assessment and screening for inpatient admission; medication monitoring; and, referral, as needed, for offenders with mental illnesses to other community services and supports to prevent re-offending and involvement with law enforcement.

South Carolina has three mental health courts, in Charleston, Richland, and Greenville counties. Mental health courts have single dockets, which specifically address issues of persons with mental illnesses who become involved with law enforcement and the criminal justice system. The Probate Court serves as the lead agency, in partnership with SCDMH's community mental health centers and other stakeholders from the Public Defender's Office, the Solicitor's Office, DAODAS, and SC Probation, Parole and Pardon Services. The mental health courts are funded by county governments and SCDMH's community mental health centers. Services offered

include: crisis management; case management; individual, family and group counseling; and groups, in the areas of Criminal Thinking, Substance Abuse and Anger Management.

South Carolina has 45 jails that incarcerate inmates in 47 counties. CMHC's are providing jail services, which include outreach, transportation, and consultation in 84 percent of the jails. This leaves seven county jails that do not receive any type of mental health services from the CMHC's. Six of the 45 county jails have formal contracts with the CMHC's and 18 of 45 county jails have formal contracts directly with private providers. The CMHC's have reported an increase in services to 17 county jails, while reporting a decrease in two county jails. Fifteen CMHC's are providing mental health services in the county jails, and 31 county jails are transporting inmates to CMHC's for mental health services.

Recommendation:
At the time of the monitoring visit, SCDMH did not have a formal MOA with the Department of Corrections that monitored Re-Entry services for individuals with SMI. It is recommended, an MOA be implemented to ensure smooth transition back into community mental health services. In addition, there are only three mental health courts in the entire state. It is recommended, the state explore options to increase mental health courts to divert consumers from incarceration and instead provide comprehensive services for consumers who are experiencing increased symptoms of their mental illness.

Deaf Services
SCDMH's Deaf Services provides a continuum of outpatient and inpatient behavioral health services to persons who are Deaf and Hard of Hearing. The program develops innovative technological and human service program initiatives to ensure all services are delivered in a cost-effective and timely manner throughout the state. Components include; Outpatient services for children, families, and adults, using itinerant counselors who are part of regional teams located across the state. School-based services are offered in collaboration with the South Carolina School for the Deaf and the Blind. Residential services in supported apartments at locations across the state. Inpatient services at Patrick B. Harris Hospital and William S. Hall Psychiatric Institute.

Recommendations for Improvement and Technical Assistance

- SCDMH needs to improve areas that are directly related to access to care, data exchange and collection, utilization and retention concerns within the states system of care for six populations. These populations include:

    - Eighteen, 26 year olds;
    - Youth In Transition;
    - Consumers with both a substance use disorder and a SMI in rural areas;
    - Individuals involved in the criminal and juvenile justice system; and
    - LGBT and Hispanic/Latino individuals accessing services.

Children Services

The SCDMH aims "to ensure that all families are equal partners in the decision making processes that affect their children. It is the state's contention that familial participation is an essential component of treatment and recovery." To that end, the state has a performance

measure of client perception of care that hopes to achieve strong agreement/satisfaction on care rendered. Services include health, mental health, and rehabilitation treatment; employment; housing; substance use; medical and dental; support; education; case management; co-occurring; and activities to reduce hospitalization.

Joint Council on Children & Adolescents for the past four years, the Joint Council on Children & Adolescents has led efforts to improve services for children and youth needing treatment services across systems to include mental health, substance use and care coordination. The body was established in August 2007 as a mechanism for transforming the service delivery system of youth and their families. The Council's mission requires participating agencies to commit to the delivery of cost effective, quality service, which emphasizes a "No Wrong Door" approach.

The Joint Council has recently revised its bylaws to incorporate "System of Care" and "Trauma Informed Care" language. Products of the "Trauma-Informed Care" initiative include six hour training on eight trauma-informed core competencies approved by the Joint Council. These trainings are provided to the public at no cost and are presented in regions across the state. Through the Breaking Boundaries planning grant, SC has created a statewide strategic plan to implement a best practices, child- and family-centered approach to services and supports. With the full support of the Joint Council on Children and Adolescents, and a broad base of involvement from agencies, organizations, youth, and families, the state has moved towards the next phase of implementation.

Children, Adolescents and their Families (CAF) Services develops and aspires to implement a seamless statewide system of care for children, adolescents and families of South Carolina including, ensuring the use of best practices when appropriate and possible. Best Practice programs includes; MST, School-based Services, Trauma-Focused Cognitive Behavioral Therapy and Parent-Child Interaction Therapy (PCIT). The CAF Division assumes a leadership role and provides staff support to the Joint Council on Children and Adolescents, providing a "No Wrong Door" collaborative to increase access to services, and supports for families living with mental health, substance abuse and co-occurring concerns, and through the Palmetto Coordinated System of Care. The CAF Division serves as the central hub of communication for local CAF directors, providing consultation services, technical assistance, and serves as a monthly forum for the discussion and problem solving of issues relative to Children's Services.

SCDMH also exemplifies providing services for the whole person and whole family. State, local and non-governmental organization's collaborations and partnerships ensure a comprehensive service delivery to both children and families with a strong emphasis on person-centered treatment. The child and youth services stand as a model for the adult system to replicate so it can reduces access to care issues and provide statewide-standardized services for everyone.

Some examples of the service delivery system for children and youth include the following:

Parent-Child Interaction Therapy
PCIT is an empirically supported treatment for young children (ages 2 to 7) with emotional and behavioral problems. Emphasis is on improving the parent-child relationship and changing parent-child interaction patterns. PCIT draws on attachment and social learning theories, and treatment can last from 14 to 20 weeks. This treatment model is divided into two phases: Child

Directed Interventions - promotes secure attachment as it restructures the parent-child relationship. Parent Directed Interventions - parents learn to use effective and consistent contingency strategies to manage their child's behavior. In PCIT, the therapist coaches the parent in real time and in specific skills as the parent engages in interaction with his or her child.

Project BEST

Bringing Evidence Supported Treatment to South Carolina Children and Families (BEST). Project BEST is a state-wide collaborative effort to use innovative community-based dissemination, training, and implementation methods to dramatically increase the capacity of every community in South Carolina to deliver evidence-supported mental health treatments to every abused and traumatized child who needs them.

The South Carolina Trauma Practice Initiative, a public-private partnership including DMH, DSS, MUSC National Crime Victim's Center, Dee Norton Lowcountry Children's Shelter, and The Duke Endowment pooled resources to provide Trauma-focused Cognitive Behavioral Therapy (TF-CBT) training to approximately 624 multi-agency staff statewide through Project BEST.

Training for this program is completed over a 24-month period through Community-Based Learning Collaboratives (CBLCs) that provide nine-months of intensive training in this evidenced-based practice under the instruction and clinical oversight of nationally recognized MUSC Project BEST faculty. Outcomes Training began in January 2014 and will continue until TF-CBT services are available in every part of the state. At the completion of this trauma practice initiative, a majority of the Child & Adolescent clinical workforce within DMH will be trained and "rostered" in TF-CBT evidenced based intervention. As of February 1, 2015, there are approximately 246 DMH child clinicians who have completed or receiving this evidenced-based training through TF-CBT Community-based Learning Collaboratives (CBLCs), operable in the Spartanburg-Beckman, Grand Strand, Midlands, Upstate and Lowcountry areas.

The Assessment & Resource Center

The Assessment & Resource Center is a CAC, accredited through the National Children's Alliance in Washington, DC. It is the only state funded CAC in South Carolina. DMH collaborates with the USC School of Medicine's Department of Pediatrics and Palmetto Health Children's Hospital to provide integrated services for children suspected of being sexually or physically abused. The Assessment & Resource Center also provides *ChildFirst* training in forensic interviewing techniques for law enforcement and child protection professionals, in partnership with the Children's Law Center of the University Of South Carolina School Of Law.

The Center was administratively transferred from SCDMH's Division of Inpatient Services to its Columbia Area Mental Health Center in July 2014 and serves approximately 600 children each year. The Assessment & Resource Center provides:

- Court preparation for child witnesses;
- Forensic interviews and medical exams;
- Expert testimony in Family and Criminal Court; and
- Victim advocacy.

Integration of Behavioral Health and Primary Care
SCDMH co-located staff with Carolina Health Centers, Inc., based at The Children's Center. The Children's Center is a large pediatric practice with up to seven providers including pediatricians and nurse practitioners. The staff member from BCMHC carried a caseload, providing individual, group, and family counseling to clients – ranging in age from 2-3 years up to age 18 – and their families that were referred by said providers. Referrals were made via their EMR with follow up allowed for in their system's "Notes" sections. In accepting referrals and providing counseling/therapy services, staff also provided staffing times and consults with the providers when needed, assisted with warm hand-offs in office, and provided parenting information, problem solving skills, and information on mental health issues that present themselves in the child and adolescent population.

The previous SAMHSA monitoring visit indicated, the state needed to address the over medication of children and youth with serious emotional disturbance. The state did not directly address this issue but certain CMHC's did establish partnerships with local FQHC's and Pediatric Practices and implemented cross training with all of the prescribers of psychiatric medications.

Recommendation:
SCDMH needs to address this concern statewide by operationalizing medication practices, policies, or algorithms that ensure evidence-based care is rendered and strategic cross training for medical staff and medication prescribers at FQHC's.

Accessibility, Coordination, and Continuity School-Based Services (Strength)
South Carolina has an array of services available to them in their home communities or regional basis, at the very least, and child and adolescent mental health professionals utilize a "best practices approach" in caring for children and families, we are privileged to serve.

The state works from the framework that all families are equal partners in the decision-making processes that affect their children and that familial participation is an essential component of treatment and recovery. To that end, the department seeks to make services accessible to families with respect to physical proximity, service delivery sites, and overall program operational procedures.

The states goal is to build a seamless service delivery system for the children and families of South Carolina. SCDMH are exploring new avenues for linking families with critically needed mental health services in the home, school and community settings. Some include the wraparound model of service delivery that is family centered and are forming partnerships with sister agencies to provide community based services such as Multi-Systemic Therapy, school based services, wrap services, etc. The state has successfully operated two federally funded, wraparound projects within our service delivery system and are now ready to move forward with the statewide expansion of this treatment philosophy.

The Division of Children, Adolescents, and Their Families is committed to improving the system of care for children, adolescents, and families across the state. We will endeavor to achieve this goal by continuing to form partnerships with community partners, sister agencies, advocacy

groups and families. With persistence, determination and the combined will of the many stakeholders, South Carolina will have a state-wide system of services for children and families, that is child centered, family focused, community based and culturally competent.

The Division of Children, Adolescents, and Their Families partners with other child serving agencies to expand and enhance the system of care that is available to the children and families of South Carolina. Thus, we have formed inter-agency initiatives across the state in an on-going effort to meet the needs of our shared populations, therefore, improving the quality of life for the children, adolescents and families that we are privileged to serve.

Child Mental Health/Adoption Initiative
This service exists to aid individuals and families at various stages of the adoption process. Individuals may be served during the pre-adoptive, adoptive, and post-adoptive phases of the adoption process. A mental health professional is out stationed in the DSS Adoption Office. The purpose of the initiative is to provide supportive services to families in an effort to increase the likelihood of adoption consummation.

Child Mental Health/Child Welfare Initiative
This service exists to provide support and assistance to children in the foster care system. The purpose of this initiative is to promote family reunification, minimize the length of time a child spends in foster care, and ultimately, reduce the number of children entering the foster care system. Mental health professionals are out stationed at local DSS offices in an effort to provide support and consultation to DSS workers regarding issues relative to foster children. Service provision is not office-based or traditional. Mental health professionals provide home and school visits. They facilitate referrals from child welfare workers to child mental health when appropriate.

Child Mental Health/DJJ Initiatives
These initiatives represent a partnership between mental health and juvenile justice. This initiative serves to divert youth with serious mental illness or serious emotional disturbance from the criminal justice system and ensure children and adolescents who have already penetrated the system have access to appropriate care and services.

DMH serves children and adolescents at all levels of the juvenile justice spectrum including youth on probation, parole and those committed to the DJJ institutions. Mental health professionals are out stationed in county DJJ offices in several catchment areas. Diversion programs targeting status offenders are available at eight CMHCs. These early intervention programs strive to keep youth in home, in school and out of trouble (DJJ). Additionally, the department partners with DJJ to provide intensive family services using the Multi-Systemic Therapy Model at four (4) CMHCs.

DMH provides services to seriously mentally ill youth committed to DJJ. A federal class action lawsuit was filed against DJJ. The lawsuit resulted in the formation of a subclass of youth classified as SMI. The court found these youths, though committed to DJJ, must be transferred to the agency best qualified to treat them, SCDMH. While there is no longer a lawsuit, SCDMH and DJJ have established a Memorandum of Agreement to serve juveniles who are SMI. These

youths are transferred to SCDMH for placement in a therapeutic setting. However, they remain committed to DJJ and are under the jurisdiction of the SC Board of Juvenile Parole.

DJJ and DSS Family Preservation/Multi-Systemic Therapy Initiatives
These programs work closely with DJJ and DSS to prevent the removal of children from the home and to stabilize and strengthen the child/family's functioning and adjustment. Family preservation is an important clinical intervention that is often used to reunite children with their families.

Shared Purchase of Residential Treatment Services
This service is primarily a fiscal vehicle through which the Department of Mental Health secures proportionate funding from all agencies having some programmatic responsibility for the child being served (i.e., the child is eligible for the services of multiple state agencies). Upon making the determination that a child has multiple needs that require the services of other child-serving agencies, a staffing is convened by the "lead agency" for the purposes of developing a comprehensive and coordinated treatment plan, and determining each agency's proportionate share of the costs. In the case of children in DSS custody, agencies contribute annually to a legislatively mandated pooled services fund, which can then be accessed to pay service costs for eligible consumers.

Interagency System of Care for Emotionally Disturbed Children (ISCEDC)
The purpose of this program is to establish a pooled services fund, and prescribe an interagency service planning process for addressing the needs of emotionally disturbed children in DSS custody. ISCEDC is a legislatively mandated program aimed at placing the decision-making responsibility and funding authority for therapeutic residential placements at the local level. County-based Interagency Staffing Teams (IST), which includes a representative from DMH, reviews clinical information to determine ISCEDC eligibility and the initial level of therapeutic care that is needed. IST has been established in each county and include, at a minimum, DSS/Managed Treatment Services, DSS/Regular Foster Care and DMH. Other agencies such as COC, DJJ, school districts, local drug use and alcohol DAODAS, and DDSN would participate if they are involved or are expected to become involved with the child.

A child may be referred for an ISCEDC staffing if he/she is either at-risk or in need a therapeutic residential placement. The goals of the ISCEDC program are to ensure, children are placed in therapeutic residential placement only when necessary, and ensure such placement is the least restrictive, most appropriate level of care for addressing their treatment needs. Services paid from this fund include therapeutic placement services and wraparound.

Specialized Residential Programs for Under-served Populations of Youth
SCDMH partners with public and private agencies to meet the needs of severely emotionally disturbed children and adolescents whose needs are too complex to be met by the state's current service delivery system. SCDMH partnered with the Governor's Office, Office of Children's Affairs to provide start-up funding for the development of high management rehabilitative services for deaf children who have SED. This program is operated by the Center for Change. SCDMH also partnered with the Governor's Office of Children's Affairs, Department of Disabilities and Special Needs and the Department Social Services/ Division of Managed

Treatment Services in the development of New Pathways, high management rehabilitative services for dually diagnosed severely emotionally disturbed youth. New Pathways is located in House 5 on SCDMH grounds and is operated by Mentor, Inc.

This Best Practice program seeks to identify and intervene at early points in emotional disturbances and assist parents, teachers, and counselors in developing comprehensive strategies for resolving these disturbances. Services include:

- Primary prevention – (e.g., helping to increase parental involvement in school, helping to coordinate activities related to a violence prevention initiative.).
- Early intervention and services to youth dealing with transitions and milestones – (e.g., social skills training, school transition programs.).
- Individual and family services – (e.g., individual, family, and group counseling, crisis intervention, mentoring, tutoring.).

Homeless Services
Formal linkages with the school system and juvenile justice, substance abuse treatment, and general social services allow for care coordination of runaway and homeless children. The SCDMH funds approximately 1,600 housing units for individuals and families, operates PATH programs, participates in the South Carolina Interagency Transportation Council, coordinates with the South Carolina State Housing Finance and Development Authority, and operates a statewide Tele-Psychiatry Program available to hospital EDs to assess children in crisis. The state acknowledges that rural homelessness is a concern due to the lack of available services.

Suicide Prevention
SCDMH has received a youth suicide prevention grant of $736,000 per year, for five years, from SAMHSA. The award, which will begin September 30, 2015, will support the Young Lives Matter Project (YLM), an intensive community-based effort with a goal of reducing suicide among youths and young adults, aged 10 to 24, by 20 percent statewide, by 2025.

This initiative involves partnerships between our Agency and the American Foundation for Suicide Prevention–SC, Mental Health America–SC, the Federation of Families–SC, the National Alliance on Mental Illness–SC, and others. YLM will focus on increasing access to screening and mental health services for youths and young adults; raising awareness through social media marketing; providing suicide prevention programming in 80 school districts, five college campuses and with a goal of reaching 300,000 youth and young adults; and increasing protective factors by training teachers, parents, peers, guidance counselors and others on recognizing suicide risks, and where to get help for depression and other mental health issues. Other goals of the initiative include development of interagency protocols in the event that a youth or young adult is determined to be at risk of suicide; support for clinicians and educators in implementing evidence-based interventions; and training for ED staff on suicide means restrictions.

Mental Health Planning Council

The South Carolina Mental Health Planning Council is mandated by federal and state statute to: advocate for children with serious emotional disturbances (SED), and adults and older adults

with serious mental illness (SMI); to review and report on the public mental health system; to participate in statewide planning; and advise the Legislature on priority issues.

The Council complies with the federal requirements regarding membership composition in that no less than 50 percent of the Council is consumer and family-members. The Council membership reflects the stakeholder community. The Council includes adult consumers, family members of children, representatives from advocacy organizations, and representatives from all the required state agencies. The Council members are active and involved in their role of advocating for the mental health system.

The members of the Mental Health State Planning Council reported, they have a positive relationship with SCDMH leadership and feel they provide input into the development of the Mental Health Block Grant (MHBG) Plan and annual Implementation Report. The Council members shared that they represent the geographic and ethnic diversity of the state. The Council members do feel they fulfill their role with regard to the duties identified in the Block Grant legislation, including reviewing the State Plan, making recommendations concerning the Plan, advocating for adults with SMI and children with SED, and reviewing and evaluating (on an annual basis) the allocation and adequacy of mental health services within the state.

Council members report active involvement in systems change initiatives and processes that influence the future direction of the mental health system. The Council contributes to the state's planning process by keeping the state informed on promising and successful practices in the communities the Council visits and by sharing concerns raised at public forums and at quarterly meetings. They also research and report on systemic trends and emerging issues due to changes in state policy, funding, and programming.

The Council shared concerns and a need for improvement with mental health service for the following populations; Individuals with Co-Occurring Disorders, Involved in the Criminal Justice System, Living in Rural Areas, Transition Age Youth, Latino and LGBTQ. In addition, they had the following recommendations for SCDMH;

- Provide more Peer Support for individuals with Co-Occurring Disorders;
- Increase access to services for individuals living in rural areas with transportation issues;
- Improving re-entry services for individuals coming out of the criminal and juvenile justice systems;
- Increasing bi-lingual and cultural competent staff;
- Better navigation and understanding of the systems for Transition Age Youth; and
- Greater emphasis and research on early intervention and First Episode Psychosis.

The South Carolina Mental Health Planning Council requested Technical Assistance in the following areas:

- Recruiting new members that support diversity and include young adult membership; and
- Role identification and sphere of influence with key stakeholders.

Consumer and Family Member Involvement

Consumers and family members are continually involved in providing input to SCDMH regarding policy development and service delivery. The Department hires consumers and family members for state jobs. The Department has an Office of Patient Affairs, which supports the Recovery Initiative through steering, developing, and supporting patient leaders within the agency, by hiring current and former clients as: Planners and policy makers, Certified Peer Specialists, program trainers and program evaluators.

The SCDMH has established Client Advisory Boards (CABs). The CABs are established to empower clients and allow them to have the opportunity to provide the Department with input into planning, policy making, program evaluation, and service delivery. The CABs meet on a monthly basis and are in place at each of the CMHCs and all of the state hospitals.

The SCDMH has a clearly defined client rights system with policies and procedures that note time-lines and standards. Clients receive a copy of their rights when services are initiated. Client rights are posted at all of the program service sites.

During the visit, the monitoring team had the opportunity to videoconference with approximately 40 Client Affairs Coordinators (CAC). The primary areas of discussion included; Access to Services, Employment, Trauma, and Interpersonal Violence Support Groups, Tele-Psychiatry and access to pharmaceuticals in rural areas, housing, and quality of services from mental health staff. The CAC had numerous recommendations to improve behavioral health service delivery.

Recommendations:

- Video Conference with all the CAC's statewide on a monthly basis;
- Increase employment opportunities;
- Meet with the Mental Health Planning Council on a consistent basis through video conference;
- Provide Gender Specific support groups on-site for Sexual Abuse, Trauma and Interpersonal Violence; and
- Statewide implementation of fitness and nutritional programs.

Five Percent Set-Aside

In its fiscal year 2014 appropriation, the states have been required to set aside five percent of their MHBG allocation to support "evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders." The congressional language "notes that the majority of individuals with severe mental illness experience their first symptoms during adolescence or early adulthood." The language also notes "[d]espite the existence of effective treatments, there are often long delays – years and sometimes decades – between the first onset of symptoms and when people receive help." Congress specifically provided an increase to the MHBG over the FY 2013 level to help states meet this new requirement without losing funds for existing services and programs. In its guidance to the states, SAMHSA noted that this set-aside funding is dedicated to treatment for those "with early serious mental illness" and not for primary prevention or preventive intervention for those at high risk of serious mental illness.

SCDMH implemented the evidence based Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT) as the treatment modalities it would deploy utilizing the Five Percent Set Aside. In addition to these modality's, the state is also, incorporating other program activities such as Dialectical Behavioral Therapy (DBT), CPSS, Telemedicine, Mental Health Courts, Supported Apartments for Youth-in-Transition, Care Coordination for Youth and Families, and Individual Placement & Supported Employment (IPS). These value-added linkages have enhanced the total effectiveness of this approach and outcomes.

Three CMHC's Lexington, Charleston, and Pee Dee were funded with the Five Percent Set Aside for First Episode Psychosis. Lexington was the CMHC visited during the site review. Staffing the Program in Year 1 was one of the more significant challenges to full implementation of the Program. This is one reason that the entire amount for the Program was not expended however; SCDMH did provide services during Year 1 as the Program was partially implemented. In total, SCDMH provided services to 247 individuals. In an effort to expand the service region of the Five Percent Set Aside for First Episode Psychosis, the state awarded CMHC's) to expand their efforts into their satellite mental health clinics in which FEP services were added to staff responsibilities where said responsibilities had not previously existed.

Data Collection and Reporting

SCDMH will utilize its ability to track client-level data via its electronic medical record to provide aggregated outputs (counts) and outcomes (results) to SAMHSA to demonstrate the effective and efficient use of the Five Percent Set-Aside for First Episode Psychosis funds. SCDMH is able to identify both the clinicians and the patients involved in the Program, so data specific to the Program can be reported.

SCDMH plans to work with Dr. Meera Narasimhan and her team at the University of South Carolina, School of Medicine to evaluate outcomes at the three initial sites that have begun this Program. Outcomes will include clinical and social parameters. Clinical measures of outcome will include psychopathology, hospitalization, and suicidality. Social parameters will include quality of life functioning, employability and the ability to live independently.

SCDMH will work with Dr. Narasimhan to determine those outcome measurements appropriate to demonstrate the efficacy of the Program beyond reporting only number of patients served.
Planned Activities for the Future

At present, it is the intent of SCDMH to maintain funding at current levels ($350,000) for the initial sites of the program. This program will be referred to as "The Traditional Program."

Lexington County Community Mental Health Center, Summary of Data

Number of clients Served:

- Total number of clients currently receiving serves: 85
- Percentage of total LCCMHC clients 18-30 years old: 18 percent
- Total number of clients served by Grant since initiation: 180
- Percentage of total LCCMHC clients 18-30 years old: 38 percent
- 1,399.18 hours of direct client services provided 4/1/2015-2/26/2016.

Demographics:
Females: 61 percent Males: 39 percent

- African American: 17 percent
- Two or more races: two percent
- Caucasian: 73 percent
- Not stated: eight percent

Diagnosis:

- Schizophrenia: 42 percent
- Other psychotic d/o: 14 percent
- Bipolar: 23 percent
- Major Depression: 19 percent
- Other MH Diagnosis: four percent
- Co-Occurring Substance Abuse d/o: 16 percent

Special Collaborations and Responses

Response to the Mother Emanuel AME Shooting

On the evening of Wednesday, June 17, 2015, 10 people were shot in an attack during a prayer service at Emanuel AME Church in Charleston. Nine of the victims died. In collaboration with local law enforcement and community groups, the staff from Charleston-Dorchester MHC (CDMHC), were able to respond immediately in the wake of the tragedy. The Center reached out to victims, their families, the Emanuel Community, the Office of the Mayor, first responders EMS, law enforcement, the coroner's office), the Media, victims' advocates, and the community at large.

Within two hours of the event, the CMHC began providing psychological first aid, crisis counseling, and mental health/behavioral health services, while coordinating with other agencies, including local law enforcement. It had also begun to coordinate behavioral health services to affected individuals, families, communities, and responders. In less than 24-hours after the event, the CMHC had activated its internal Emergency Response Team and SCDMH's Central Office had coordinated resources from its other CMHC to support the staff of the Center. The CMHC also established direct communication with the City of Charleston, non-governmental agencies, the Federal Bureau of Investigation's (FBI) Victims Advocate, Charleston Police Department Victims Advocate, and staff from the Office of the Governor of the State of South Carolina. By 1:00 p.m. on the day following the event, a counseling phone bank had been established in conjunction with the local CBS affiliate. By 2:00 p.m., a staff member from the Center was placed at the Family Assistance Center established by the FBI. By 4:00 p.m., CMHC staff members were preparing trauma response information for its website, which had already distributed to external parties. SCDMH Central Office staff members were ordering similar information for churches to include with local worship bulletins. Less than 24-hours after the event, the Center had already begun assisting with the development of behavioral health risk

communications and public messaging. It had also begun distributing psycho-educational materials.

Less than 48 hours after the event, the Center was coordinating response efforts with the South Carolina State Office on Victim Assistance, the Medical University of South Carolina's National Crime Victims Research and Treatment Center and the Charleston County Sherriff's Office. CMHC staff had also re-established its support role at the FBI's Family Assistance Center. SCDMH Central Office staff had communicated with SAMHSA and customized information materials were in development. Less than 48 hours after the event, the CMHC had already begun assisting with referrals to appropriate local, state, and federal resources. Collaboration and cooperation ensured that victims' needs were addressed in a timely and orderly manner by the organization most appropriate for the need.

The following is a brief summary of services provided by Charleston-Dorchester MHC and its partners following the shootings. CDMHC quickly collaborated with multiple community partners. Together, these partners were able to provide immediate access to care, via: Family Assistance Center, Church Assistance Center, Regular and timely debriefings, Funeral planning meetings, Phone banks and interviews, Community assistance at the Mental Health Centers, Support presence at prayer vigils, Support presence at every victim's wake and funeral, and the Highway to Hope RV presence at the memorial service at Emanuel AME.

Partners continued to provide support in the following weeks and months, including:

- Counselors at every worship service
- Presence at all court hearings
- Counselors at various ministry meetings
- Church bulletin inserts
- Grief support groups
- Individual therapy
- Applying for a Victims of Crime grant to provide ongoing support
- Opening a Recovery Center for victims and the community at large
- Case study, outlining actions taken, outcomes, and lessons learned
- Ongoing grief groups - two per week
- A retreat for families of the victims

The group who responded to this tragedy was careful to ensure they "Cared for the Caregivers"; many staff at the nearby MHCs knew victims or their families. To ensure those providing services to others were addressed the MHC's held internal "town hall meetings", conducted debriefings, provided ongoing training and consultation, ensured constant communication, received ongoing SCDMH Central Administration support, and most importantly, the CDMHC and its partners have made sure the local community knows they are "in it for the long haul," and will continue to provide support as long as it is needed. This was a model behavioral health example of how to respond to a devastating shooting in a state and community.

National Guard Project
SCDMH has collaborated with the South Carolina National Guard (SCNG) to give priority and provide outpatient mental health services to soldiers, using a linkage of SCDMH and SCNG liaisons to facilitate treatment at local mental health centers. Since April 2014, the SCNG staff has referred 14 soldiers and three family members to local SCDMH centers or clinics for treatment. SCDMH and SCNG staff have participated in two statewide conferences on understanding military culture and have held several individual meetings to establish an acceptable referral protocol, understand military culture, and ensure continuity of soldiers' treatment.

Launched in 2011, the Star Behavioral Health Providers program trains civilian mental and behavioral health professionals on the unique aspects of military life. It is a collaborative effort of the Center for Deployment Psychology, which provides training, and the Military Family Research Institute at Purdue University in Indiana. The program helps service members and those who care about them locate trained civilian behavioral health professionals who better understand challenges associated with military service. Once mental health professionals complete these courses, their names are added to the Military Family Research Institute's confidential registry, which can be searched by reserve and guard members and veterans.

Behavioral Health for First Responders
In July 2013, SCDMH joined the South Carolina State Firefighters' Association, the South Carolina Fire Academy, and the National Fallen Firefighters Foundation, in launching a pilot program to provide behavioral health support to South Carolina's 17,500 firefighters. The goal is to ensure behavioral health interventions are available to firefighters when needed, and the care provided represents best practices. The program provides clinical intervention; firefighter peer teams provide first-tier response, and SCDMH provides second-tier clinical support. The program is the first of its kind in the nation, and will serve as a national and international model.

FINANCIAL MANAGEMENT

This section presents the results of SAMHSA's review of Department of Mental Health, fiscal management policies and procedures, information systems, expenditure reports, and supporting documentation related to the state's management of MHBG awards.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objectives were to, (1) assess the state's ability to accurately account for, and report on, MHBG and related mandatory non-federal expenditures, and (2) determine if the state has complied with grant requirements regarding:

- activities allowed or un-allowed;
- allowable costs/cost principles;
- level of effort;
- earmarking;
- period of availability of federal funds;
- financial reporting;
- special tests and provisions; and
- sub-recipient monitoring.

Scope

We reviewed the state's systems for, (1) federal cash management, (2) allocation of federal resources, (3) federal financial reporting, (4) procurement of mental health services, (5) sub-award and contract management, (6) sub-recipient monitoring, and (7) MHBG compliance. We also reviewed the state's expenditure of MHBG funds from federal fiscal year (FFY) 2011 through FFY 2014 awards and related mandatory non-federal expenditures for state fiscal year (SFY) 2011 through SFY 2015.

Methodology

Prior to the onsite visit, we reviewed documents provided by DMH including pre-site tables 7-10 that reported expenditures for the periods under review. Onsite, we interviewed DMH's staff to review the agency's policies and procedures (P&Ps) related to, (1) federal cash management, (2) allocation of MHBG resources, (3) federal financial reporting, (4) procurement of mental health services, (5) sub-award and contract management, and (6) sub-recipient monitoring. We also reviewed documentation for expenditures reported to SAMHSA and traced those expenditures to DMH's financial management systems. In addition, we participated in site visits of two providers: Federation of Families of South Carolina and the National Alliance on Mental Illness of South Carolina. During those visits, we reviewed the capability of those organizations to manage MHBG grant funds and their compliance with the terms and conditions of their awards.

OBSERVATIONS

1. **Cash Management and Sub-recipient Monitoring Requirements Were Not Addressed in Written P&Ps**
   - **Condition:** DMH Department of Health Care Services (DHCS) did not have any written P&Ps that addressed how the Agency complies with SABG cash management and sub-recipient monitoring requirements.

   - **Criteria:** The following criteria are applicable-
     - Per 45 CFR § 96.30 (a), "Fiscal control and accounting procedures must be sufficient to, (a) permit preparation of reports required by the statute authorizing the block grant, and (b) permit the tracing of funds to a level of expenditure adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of the statute authorizing the block grant."

     - Title 31 CFR § 205.11 (b) requires states to, (1) minimize the time elapsing between the transfer of funds from the United States Treasury and the state's payout of funds for federal assistance program purposes, whether the transfer occurs before or after the payout of funds, and (2) limit the amount of funds transferred to the minimum required to meet a state's actual and immediate cash needs.

     - OMB circular A-133 (A-133) §__.400 (d) requires each pass-through entity to monitor the activities of sub-recipients as necessary, to ensure that federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved.

   - **Cause:** DMH did not have sufficient fiscal controls and accounting procedures to ensure, DMH had developed P&Ps that addressed cash management and sub-recipient monitoring.

   - **Recommendation**: DMH should develop P&Ps addressing cash management and sub-recipient monitoring and ensure staff administering the MHBG is knowledgeable of those requirements.

2. **DMH Did Not Meet 5 Percent Expenditure Requirement of First Episode Psychosis Services (FEP) in FY2014.**
   - **Condition:** SAMHSA awarded DMH a FFY 2014 MHBG award of $6,671,692. DMH was required to spend 5 percent of its FFY 2014 MHBG award ($333,585) on FEP services; however, DMH only spent $155,298 of the required amount.

   - **Criteria:** P.L. 113-76 and P.L. 113-235 required states to set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early serious mental illness (SMI) including but not limited to, psychosis at any age.

- **Cause**: DMH lacked adequate planning and fiscal controls to ensure MHBG FEP expenditure requirements were met.

- **Recommendation:** DMH must develop adequate planning processes and fiscal controls to ensure MHBG FEP expenditure requirements are met. DMH staff must also consult with their MHBG project officer at SAMHSA to determine what corrective actions need to be implemented to address the state's noncompliance with the FEP spending requirement for the FFY 2014 MHBG award.

3. Insufficient Sub-recipient Monitoring

- **Condition:** DMH did not, (1) require providers to submit their single audit reports (SAR) to DMH, (2) review the audit reports, or (3) follow up on any audit finding that required corrective actions.

- **Criteria:** A-133 §__.400 (d) requires each pass-through entity to ensure sub-recipients expending $500,000 or more in federal awards during the sub-recipient's fiscal year have complied with the A-133 audit requirements for that fiscal year.

- **Cause:** DMH lacked internal controls to ensure DMH staff complied with sub-recipient monitoring requirements of A-133.

- **Recommendation**: DMH must develop P&Ps and implement controls to ensure DMH staff adequately monitors MHBG providers in accordance with applicable requirements.

EXPENDITURE ANALYSIS

Obligated and Expended Funds

Table 1. Summary of State Mental Health Expenditures by Revenue Source

Revenue Source	SFY 2014	SFY 2015
State General Funds	$176,381,598	$192,875,727
Other State Funds (specify)	$0	$0
MHBG Funds	$5,950,960	$6,779,681
Other Federal Funds (specify)	$2,412,684	$2,207,392
Medicaid Funds	$121,784,359	$119,923,605
Other (specify)	$53,357,666	$64,223,096
Total	$359,887,267	$386,009,501

Table 2. Summary of Obligated and Expended Funds[1]

Federal Fiscal Year	Total Award	Obligation Period	Amount Obligated	Expenditure Period	Amount Expended
FFY 2011	$5,882,807	10/1/2010-9/30/2012	$5,882,807	10/1/2010-9/30/2012	$5,882,807
FFY 2012	$6,363,877	10/1/2011-9/30/2013	$6,337,877	10/1/2011-9/30/2013	$6,337,877
FFY 2013	$5,955,461	10/1/2012-9/30/2014	$5,955,461	10/1/2012-9/30/2014	$5,955,461
FFY 2014	$6,671,692	10/1/2013-9/30/2015	$6,476,990	10/1/2013-9/30/2015	$6,476,990

[1]Any amounts paid to the state for a fiscal year shall be available for obligation and expenditure until the end of the fiscal year following the fiscal year for which the amounts were paid (42 U.S.C. 300x-62).

State MOE Expenditures

Table 3. State MOE Expenditures[1]

Period[3]	State Expenditures[2]	Previous Two-Year Average Expenditures	Percent Over/(Under) MOE Requirements
SFY 2011	$63,182,404		
SFY 2012	$63,834,842		
SFY 2013	$66,940,745	$63,508,623	5.4%
SFY 2014	$69,027,628	$65,387,794	5.57%
SFY 2015	$69,870,114	$67,984,187	2.77%

[1]The state shall, for each fiscal year, maintain aggregate state expenditures for community mental health centers at a level that is not less than the average level of such expenditures maintained by the state for the two state fiscal years preceding the fiscal year of the grant (42 U.S.C. 300x – 4 (b)).

[2]Actual expenditures listed under the "State Expenditures" column, are averaged and the average of the two-year period is placed in the "Previous Two-Year Average Expenditures" column on the line next to the fiscal year studied.

[3]The state fiscal year listed in Table 3 should cover the two most recently completed SFY.

Children's Set-aside Expenditures

Table 4. Children's Set-aside Expenditures[1]

Period	State Children's Set-aside Expenditures	MOE Base	Difference
SFY 2011	$13,372,735	$6,076,364	$7,296,371
SFY 2012	$13,715,209	$6,076,364	$7,638,845
SFY 2013	$13,007,388	$6,076,364	$6,931,024
SFY 2014	$12,046,862	$6,076,364	$5,970,498
SFY 2015	$14,119,869	$6,076,364	$8,043,505

[1]The state shall for each fiscal year expend an amount not less than an amount equal to the amount expended in fiscal year 1994 for systems of integrated services for children with serious emotional disturbance (42 U.S.C. 300x – 2 (a) (1) (C)).

Administrative Expenditures

Table 5. Administrative Expenditures[1]

Period	Maximum Allowable Expenditure	Actual Expenditure	Difference	Percentage of Difference
FFY 2011	$294,140	$0	$294,140	100%
FFY 2012	$318,194	$0	$318,194	100%
FFY 2013	$297,773	$0	$297,773	100%
FFY 2014	$333,585	$0	$333,585	100%

[1]The state may not expend more than 5 percent of grant funds for administrative expenses with respect to the grant (42 U.S.C. 300X – 5 (b)).

Evidence-based Practices for Early Intervention Expenditures

Table 6. First Episode Psychosis Services Expenditures[1]

Period	Required Expenditures	Actual Expenditures	Difference	Percentage of Difference
FFY 2014	$333,585	$155,298	$178,287	53.45%

[1]P.L. 113-76 and P.L. 113-235 require states to set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including, but not limited to, psychosis at any age.

Appendix A- Listing of Federal Monitoring Team Members

Joint SAMHSA Site Visit
February 22-26, 2016

Kim Harris, SAMHSA, CMHS Lead Monitor

Appendix B

Joint SAMHSA Site Visit
February 22-26, 2016
CMHS-Mental Health Information Sessions Participant List

February 22, 2016 – 11:00AM-12:30PM – Data Collection Systems

Leigh Ann Chmura, SCDMH, Information Technology (Central Office)
Barry Lloyd, SCDMH, Information Technology (Central Office)

February 22, 2016 – 1:30PM-4:30PM – Adult Services

Roger Williams, SCDMH, Services for the Deaf and Hard of Hearing
Debbie Blalock, SCDMH, Charleston-Dorchester CMHC
Willie Priester, SCDMH, Orangeburg CMHC
Melanie Gambrell, SCDMH, Beckman CMHC
Kevin Hoyle, SCDMH, A-O-P CMHC
Eric Turner, SCDMH, A-O-P CMHC
Tracy Richardson, SCDMH, A-O-P CMHC
Bernette Robinson, SCDMH, Berkeley CMHC
Johnette Owens, SCDMH, Berkeley CMHC
Richard Albarran, SCDMH, Berkeley, CMHC
Jenna Moorehead, SCDMH, Coastal Empire CMHC
Natashia Smith, SCDMH, Coastal Empire CMHC
Omega Smalls-Francis, SCDMH, Coastal Empire CMHC
Francis Moody, SCDMH, Coastal Empire CMHC
Angie Salley, SCDMH, Coastal Empire CMHC
Billie Jo Godwin, SCDMH, Coastal Empire CMHC
Jacob Paris, SCDMH, Coastal Empire CMHC

February 23, 2016 – 8:30AM-10:00AM – Children Services

Renaye Long, SCDMH, CAF Services (Central Office)
Lauri Hammond, SCDMH, CAF Services (Central Office)
Louise Johnson, SCDMH, CAF Services (Central Office)
Brenda Parker, SCDMH, CAF Services (Central Office)
Susie Williams-Manning, SCDAODAS, Treatment and Recovery Services

February 23, 2016 – 10:15AM-12:00PM – Children Services

Roger Williams, SCDMH, Services for the Deaf and Hard of Hearing
Holly May, SCDMH, Services for the Deaf and Hard of Hearing
Debbie Blalock, SCDMH, Charleston-Dorchester CMHC
Jennifer Roberts, SCDMH, Charleston-Dorchester CMHC
Melanie Gambrell, SCDMH, Beckman CMHC
Tacey Perillo, SCDMH, Beckman CMHC
Kevin Hoyle, SCDMH, A-O-P CMHC
Eric Turner, SCDMH, A-O-P CMHC
Carly Patterson, SCDMH, A-O-P CMHC

Christian Barnes-Young, SCDMH, Tri-County CMHC
Stacy Albarran, SCDMH, Berkeley, CMHC
Gerri Pazi, SCDMH, Berkeley, CMHC
Dr. Margaret Rittenbury, SCDMH, Berkeley, CMHC
Jenna Moorehead, SCDMH, Coastal Empire CMHC
Natashia Smith, SCDMH, Coastal Empire CMHC
Omega Smalls-Francis, SCDMH, Coastal Empire CMHC
Francis Moody, SCDMH, Coastal Empire CMHC
Angie Salley, SCDMH, Coastal Empire CMHC
Billie Jo Godwin, SCDMH, Coastal Empire CMHC
Jacob Paris, SCDMH, Coastal Empire CMHC
Sarah Stuchell, SCDMH, Coastal Empire CMHC

February 23, 2016 – 3:00PM-4:00PM – Tribal Relationships
Paul Cornely, SCDMH, Catawba CMHC
Marcy Hayden, South Carolina Commission for Minority Affairs

February 24, 2016 – 9:00AM-10:00AM – Care Coordination
Marti Landrum, SCDMH, Care Coordination (Central Office)

February 24, 2016 – 12:30PM-1:30PM – Housing and Homeless
Michele Murff, SCDMH, Housing and Homeless Programs (Central Office)

February 24, 2016 – 1:30PM-5:00PM – QA/CQI
Sandy Hyre, SCDMH, Evaluation, Training, and Research (ETR)
Ligia Latiff-Bolet, SCDMH, Office of Quality Management (Central Office)
Matt Dugan, SCDMH, Berkeley CMHC
Barry Lloyd, SCDMH, Information Technology (Central Office)
Lamar Butler, SCDMH, Berkeley CMHC
Tabitha Pressley, SCDMH, Berkeley CMHC
Cathy Parker, SCDMH, Berkeley CMHC
Jenna Moorehead, SCDMH, Coastal Empire CMHC
Tiffany Wiggins, SCDMH, Coastal Empire CMHC

February 25, 2016 – 8:30AM-12:00PM – Health Disparities, et.al.
Geoff Mason, SCDMH, Deputy Director, CMHS (Central Office)
Ed Spencer, SCDMH, Clinical and Community Innovation (Central Office)
Roger Williams, SCDMH, Services for the Deaf and Hard of Hearing
Debbie Blalock, SCDMH, Charleston-Dorchester CMHC
Elaine Fontana, SCDMH, Beckman CMHC
Mark Bellamy, SCDMH, Waccamaw CMHC
Christian Barnes-Young, SCDMH, Tri-County CMHC
Jenna Moorehead, SCDMH, Coastal Empire CMHC
Natashia Smith, SCDMH, Coastal Empire CMHC

February 24, 2016 – 11:00AM-12:00PM –

Client Advisory Boards Approximately 40 Participants
Charleston-Dorchester CMHC; Beckman CMHC; Waccamaw CMHC; Tri-County CMHC

CMHS-Mental Health Information Sessions
South Carolina Mental Health State Planning Council
Participant List*

Janie Simpson, Chair
Bill Lindsey
Jack Balling
Carol Rudder
Melissa Reitmeier
Marcy Hayden
Pheobe Malloy
Bonnie Pate
Rosemary Hedden

*Please note that as this was not an official meeting of the South Carolina Mental Health State Planning Council (Council), no sign-in sheet was posted for recording attendance. This list is a reconstruction of attendance and may not represent all members of the Council who were present. Please also note that certain members of the Council were asked not to participate (e.g. members who are also staff of the South Carolina Department of Mental Health).